

Electroshock as a Form of Violence Against Women

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This article reframes electroconvulsive therapy as a form of violence against women. Drawing on women's testimony and on scientific research, it establishes that this "treatment," which is overwhelmingly given to women, results in extensive cognitive and physical impairment. Correspondingly, it functions and is experienced as a form of assault and social control, not unlike wife battery. Emergent themes include electroshock as life destroying, a sign of contempt for women, punishment, a means of enforcing sex roles, a way to silence women about other abuse, an assault, traumatizing for those who undergo it and those forced to witness it.

Keywords: *assault; brain injury; ECT; electroshock; punishment; social control; trauma; vicarious trauma; violence against women*

As a society, we have stereotypical notions of *helper* and *violation*, and the two do not easily go together in our minds. *Professional*, moreover, is imbued with authority that allows people recognized as such to set the rules and frame the discourse. Accordingly, although we may denounce specific individuals in the "helping professions" as violators and although we may question the efficacy of certain treatments, and although, indeed, we may even go further and protest the inherent sexism or racism of a profession and urge changes, we are reluctant to typify anything currently and routinely done in the helping professions as a form of abuse, as a form of violence. I say *currently* for clearly we have no such qualms about professional practices legitimated in past eras. Note, in this regard, despite the fact that the inquisitors that burned to death hundreds of thousands of women were conventionally deemed *spiritual helpers* and *diagnostic experts* at the time, we now have no trouble typifying their actions as a form of violence against women, and a particularly horrific one at that. It is not primarily the past, however, from which people who are violated need protection. It is present practices. This being the case, it is important to interrogate current practices to see if our frame for understanding them is adequate. And if it is not, and if, in addition, severe violation is occurring, it is important to understand the nature of the injury. It is particularly important that there be such inquiry and that we be open to fundamental reframing when dealing with phenomena that have been controversial from the beginning—especially phenomena that the recipients of the "professional help" protest around the world. Such is the case with electroshock, technically known as "electroconvulsive therapy" or ECT.

Electroconvulsive therapy is a standard psychiatric “treatment” that is routinely administered in most psychiatric facilities throughout the world. Nonetheless, from its inception in fascist Italy in 1938, there have been deep concerns about it. Significantly, it immediately met with objections and qualms from recipients and professionals. As documented in Frank (1978, pp. 8-11), no sooner did the first jolt of electricity surge through the head of the first electroshock recipient than the recipient bolted upright on the table and screamed in horror, “Non una seconda! Mortificare!” (Not again, it will kill me; p. 9). Some time later, the inventor—Ugo Cerletti—acknowledged, “When I saw the patient’s reaction, I thought to myself: This ought to be abolished” (see Frank, 1978, p. 11). Since this beginning, as documented in Frank (1978), Breggin (1979, 1991, 1997), and Burstow and Weitz (1984), the questioning and the protests have continued. Researchers such as Hartelius (1952) and Breggin (1979, 1991, 1997) have alarmed people with research findings that establish damage. Throughout North America and Europe, people who identify as shock survivors and their allies routinely demonstrate against the use of shock and submit deputations on the harm done—the type of protest, significantly, which does not happen with regular or nonpsychiatric medical treatment. Legislative bodies such as the Ontario government periodically set up committees to investigate the use of shock (see, e.g., Electro-Convulsive Therapy Review Committee, 1985). Whole cities have, at times, banned the use of shock in their jurisdictions (see Burstow & Weitz, 1984). Throughout all of this protest, as evidenced in the Ontario Coalition to Stop Electroshock (1984a, 1984b) and Breggin (1997), there have been repeated claims of sexism. And yet not only has ECT continued, but as MindFreedom (2002-2003) showed, it is currently on the upswing. Moreover, it continues to be theorized as a treatment even by the professionals who oppose it. What is additionally worrisome (because we could exert pressure and have frames for understanding violence against women), it is an area largely ignored by feminist scholars despite the testimony on sexism and despite depictions by survivors and antishock advocates that suggest woman abuse. This situation is the context in which this article is written.

It is beyond the scope of this article to explore what may be needed to get beyond the current impasse. It is also beyond the scope to problematize psychiatry more generally, although aspects of a basic critique are evident. What this article does do is fundamentally shift the ECT frame and provide a critical feminist reconceptualization of electroshock—what it does and why it is given. More specifically, this article argues for and lays the basis for understanding electroshock as a form of violence generally and a form of violence against women in particular. Correspondingly, it sheds light on the nature of the violence and the manifold effects on women—psychological, social, and physical.

The article is rooted primarily in standpoint theory and, second, in institutional ethnography, in both cases as articulated by Smith (1987). The standpoint in question is the standpoint of women who have been subjected to electroshock and who have testified about it. As with all inquiry so grounded, the investigator is not neutral but is directed by the standpoint. The disjunctures and other difficulties in the lives of these

women constitute the motivation for this article, the primary object of inquiry, and the guiding problematic.

One very important source of information is articles by researchers—those who establish physical damage in particular—and it is with this research that the article begins. What follows and what forms the core of the article are comments, typifications, and protests made by women ECT survivors. The primary documents drawn on to articulate women's lived experience of ECT and its impact on them include transcripts of public hearings into electroshock that were held in Toronto (Ontario Coalition to Stop Electroshock, 1984b); a British article on themes identified in those transcripts (Baldwin & Froede, 1999); testimony of women shock survivors to the Toronto Board of Health (Phoenix Rising Collective, 1984); statements by women shock survivors in a video on women who were psychiatrized (Burstow, 1994); statements by women shock survivors in the anthology *Shrink-Resistant* (Burstow & Weitz, 1988); a book by a woman survivor on her ECT experiences (Funk, 1998); an article analyzing interviews with women given shock in the Bay Area (Warren, 1988); and a study on the traumatizing effects of electroshock on women in the United Kingdom (L. Johnstone, 2002-2003). Women shock survivors' own words are focal. Although shedding light on physical damage, these words and accounts particularly illuminate psychological traumatization. Correspondingly, they facilitate triangulation, at once validating and being validated by the research and posing claims about the social purposes of ECT. Additional sources of data include official statistics, statements by shock promoters, and my experiences as a feminist psychotherapist.

There are a number of personal locations from which I write this article. I am a woman who has never been subjected to ECT. I am also an academic who deconstructs electroshock, a feminist therapist who has worked with many shock survivors, and an activist with a lengthy history of mobilizing against ECT.

What Is ECT?

Electroconvulsive therapy is a psychiatric procedure that consists of passing sufficient electricity through the head (100 to 190 volts) to culminate in a grand mal seizure or convulsion, hence the term *electroconvulsive* therapy. For the past four decades, people administered shock have usually been given a general anaesthetic, a very powerful muscle relaxant to prevent fractures, and oxygen because the muscle relaxant renders natural breathing impossible. All such modifications, as Breggin (1991) documented, raises the seizure threshold thereby necessitating a current of greater intensity. In unilateral or modified shock, both electrodes are placed on one side of the head, whereas in bilateral or unmodified shock, one electrode is placed on each side. Typically, a single ECT series consists of at least 6 to 10 treatments (for documentation, see Breggin, 1979, 1991; Electro-Convulsive Therapy Review Committee, 1985; Frank, 1978).

Electroshock as Damage: The Research

There is ample evidence that electroshock damages the brain—evidence that clearly substantiates the protests of survivors of ECT. As early as the 1950s, animal experiments established that ECT causes brain damage. The most definitive study was Hartelius (1952). In a double-blind portion of the experiment, the pathologist examined the slides of the brains of cats, one half of which had received electroshock. Significantly, based on the observable brain damage (cell death and hemorrhages), with almost complete accuracy, the pathologist was able to identify which animals had been administered shock.

To cite relevant research on human beings with respect to modified and unmodified shock, Weinberger (1979) found more cerebral atrophy in the brains of “schizophrenics” who have had ECT than those who have not had it. And in a computed tomography (CT) scan study, Calloway (1981) found a correlation between frontal lobe atrophy and ECT.

Memory loss, intellectual impairment, and the creation of neuropathology are standard and well documented. The Electro-Convulsive Therapy Review Committee (1985) concluded that ECT has an adverse effect on memory, resulting in retrograde amnesia (inability to remember things that occurred before the administration of ECT) and antegrade amnesia (inability to retain new learning or to remember events after ECT) and found that that memory loss ranges from minor and transient to extensive and long term. An experimental study by Templer, Ruff, and Armstrong (1973) established that ECT causes permanent memory loss and general intellectual impairment. Based on a critical review of the literature—including animal and human autopsy, epilepsy and seizure studies, and studies of memory loss and intellectual impairment—Templer and Veleber (1982) concluded that ECT causes permanent brain pathology. Also based on an extensive literature review, Breggin (1998) concluded, “ECT causes severe and irreversible brain neuropathology including cell death. It can wipe out vast amounts of retrograde memory while producing permanent cognitive dysfunction” (p. 27).

The widespread damage caused by electroshock, indeed, is so clear and dramatic it has led some scientists who oppose ECT to critically redefine the procedure, making the damage done a central part of the definition. Neurologist and electroencephalographer Sidney Samant wrote,

After a few sessions of ECT, the symptoms are those of moderate cerebral contusion, and further enthusiastic use of ECT may result in the patient functioning at a subhuman level. Electroconvulsive therapy in effect may be defined as a controlled type of brain damage produced by electrical means. (quoted in Breggin, 1991, p. 184)

Although minimizing the damage done, ECT promoters defend the use of shock based on its alleged effectiveness in alleviating depression and preventing suicide. A treatment, however, would have to be exceptionally effective to warrant brain damage and extensive memory impairment, for people need their brains to navigate the world;

and memory is the basis of personal identity and of human life as we know it. And yet electroshock has no special efficacy. In a rigorously controlled double-blind study, Lambourne and Gill (1978) found that a month after shock and simulated shock, there was no difference in improvement between the patients who were administered shock and the patients who were not administered shock. They concluded that shock does not produce a superior therapeutic effect and that its alleged effectiveness is probably because of placebo. Research by E. Johnstone (1980) and Crow and Johnstone (1986) produced similar results. Moreover, Crow and Johnstone found that people improved markedly on placebo or sham shock. And placebo, significantly, does not damage the brain or cause massive memory loss. Correspondingly, research on electroshock and suicide—for example, Avery and Winokur (1976) and Black and Winokur (1989)—tell the same story: ECT has no effect on the suicide rate. Breggin (1991) concluded, “after more than fifty years there is no meaningful evidence that this dangerous treatment has any beneficial effect” (p. 207).

Effective With Respect to What?

There is a clear discrepancy between the claims of effectiveness and the research findings. This long-standing discrepancy raises the question of whether psychiatrists’ impression of effectiveness is based on something other than lowering depression and preventing suicide. Psychiatrist Peter Breggin (1991) attributed it to ECT’s ability to control behavior via fear and punishment, and he called attention to the types of statements commonly made by colleagues wanting to give shock to a patient. For example, he cited colleagues saying, “let’s throw the book at him” and a colleague telling the husband of a potential shock recipient that the treatment would help his wife “by virtue of a mental spanking” (p. 212). Such statements do indeed suggest that punishment and fear of ECT may be serving the purposes of control. In addition, psychiatry’s long and documented use of terror and torture lends support to Breggin’s position. I would draw attention in this regard to such torture apparatuses as the swivel chair and the ovary compressor and such torturous procedures as repetitively dunking a patient in ice water (for further details, see Frank, 1978; Szasz, 1977). These are ancient history to be sure; however, the haunting question of Jeanine Grobe, psychiatric survivor, (1995) seems apropos: “Is the terror inspired by the passing of electric current through the brain an improvement over the shock of being immersed in ice water?” (p. 103).

Breggin (1979, 1991) suggested an additional rationale on the part of psychiatry. He suggested that a good part of what is impressing the shock doctors is precisely the controlled behavior, memory loss, and intellectual impairment arising from brain damage. He also maintained that shock doctors are aware that brain damage is operant.

There is considerable merit to these claims. It is hard to believe that shock doctors are unaware of the extensive memory loss associated with electroshock, for in addition to an enormous literature to this effect, frequently after shock other patients and medical staff have to orient shocked patients, tell them who they are, and assist them as they try to relearn everyday routines (see, in this regard, Burstow, 1994). Correspondingly,

psychiatrists who give shock have been known to make statements that show they are counting on memory loss. By way of example, at a review board hearing that I attended as an expert witness, the psychiatrist who was seeking permission to force electroshock on a woman who was not eating took the patient's lawyer aside and told the lawyer that electroshock would solve the problem, for after shock, the woman would not remember why she was not eating and so would likely resume eating. In addition, there is reason to believe that psychiatrists who administer electroshock are aware of damage beyond memory loss, and some may also be counting on that additional damage.

Significantly, it is not only scientists who oppose shock who have testified to its brain-damaging effects. So have some very influential shock promoters. Of course, brain damage is no longer acceptable to the general public. And accordingly, nowadays shock promoters routinely deny or minimize it. In the past, however, the climate was different, so the psychiatric profession had no need to deny brain damage. This being the case, statements about brain damage made by electroshock leaders in the past have greater credibility than current statements and are an important window into understanding the use of electroshock.

An example of a current leader in the ECT resurgence whose past statements contrast with current ones is Dr. Max Fink. Although he now suggests that teachers are needed to defend electroshock against attacks alleging brain damage, in the past Fink linked brain damage and dysfunction to electroshock and "improvement." Fink (1973), for example, suggested that improvement correlates with brain dysfunction, and he connected improvement with brain trauma, cerebral dysfunction, and organic brain syndrome.

Many earlier statements by leading shock promoters are even more blunt and alarming, for they explicitly identify brain damage as the therapeutic agent and make overt the intention to damage the brain. Abraham Myerson, a psychiatrist pivotal in popularizing electroshock, is a case in point. Significantly, in discussing the desirability of ECT-induced brain damage, Myerson stated:

I believe there have to be organic changes or organic disturbances in the physiology of the brain for the cure to take place. These people have for the time being at any rate more intelligence than they can handle . . . and the reduction of intelligence is an important factor in the curative process. (quoted in Breggin, 1979, pp. 142-143)

More extreme still is the work done and the statements made by Dr. Ewing Cameron. Renowned psychiatrist and one-time head of the World Psychiatric Association, Cameron embarked on a course of treatments and experiments that combined something he called "depatterning" and "psychic driving," and ECT was the agent used to effect depatterning. The stated purpose of the ECT or depatterning was to "wipe the mind clean" and to reduce patients to the operating level of infants (in this regard, see, e.g., Cameron, Lohrens, & Handcock, 1962). There is no question that Cameron was an extreme case and that he administered considerably more shock than

was ever common. The extreme, however, serves to write large dimensions less visible in everyday use.

The point is clear. At best, damage to the integral person is being accepted as a necessary, even if unfortunate, part of electroshock. And at worst—and conventional and highly influential figures such as Myerson blatantly figure here—it is damage per se that is being seen as the source of the improvement; and it is damage per se that is being actively sought. In both cases, what is happening constitutes violence, and it is being made possible at least, in part, by a chilling disregard for people's brains.

Doctors, of course, can give electroshock for purposes of punishment and/or control without intending brain damage; and doctors can deliberately damage the brain without intending the damage as punishment or control. However, there is an overlap between these two dimensions that is meaningful. Significantly, as Breggin (1991) documented, routinely, shock doctors, including ones who actively promote brain damage, cite the patients' greater compliance as evidence of shock's effectiveness. Moreover, whatever the intention may be, brain damage renders patients more compliant and, as demonstrated in later sections of this article, the prospect of brain damage evokes terror and keeps patients in line.

Shock Statistics and the Shocking of Women

Throughout the history of ECT's popular use, one statistic remains constant. Women are subjected to electroshock 2 to 3 times as often as men. To cite as examples statistics from different eras and locations, a 1974 study of electroshock in Massachusetts reported in Grosser (1975) revealed that 69% of those shocked were women. By the same token, figures released under the Freedom of Information Act (Weitz, 2001) show that for the year 1999-2000 in Ontario, Canada, 71% of the patients given ECT in provincial psychiatric institutions were women, and 75% of the total electroshock administered was administered to women. Another statistic that seems relevant is that approximately 95% of all shock doctors are male (see Grobe, 1995).

Factor in these statistics and a frightening and indeed antiwoman picture of ECT emerges: Overwhelmingly, it is women's brains and lives that are being violated by shock. Overwhelmingly, it is women's brains, memory, and intellectual functioning that are seen as dispensable. Insofar as people are being terrorized, punished, and controlled, overwhelmingly those people are women. And what is likely not coincidental, almost all the people making the determinations and wreaking the damage are men.

Now as lawyer and shock survivor Carla McKague pointed out (Burstow, 1994), psychiatrists who promote shock frequently defend the ratio by arguing that shock is most commonly given for depression and that women are depressed approximately 2 to 3 times more often than men. And there is some truth in the position. Indeed, given a sexist society, women have reason to be more depressed. The defense, nonetheless, is empty. Brain damaging, controlling, and terrorizing women hardly changes the oppressive conditions in which women live. In addition, as has already been shown, electroshock has no special efficacy in relieving depression. Moreover, as the Electro-

Convulsive Therapy Review Committee (1985) found, women are electroshocked 2 to 3 times as often as men irrespective of whether or not they are depressed, irrespective of diagnosis.

None of the justifications add up. Indeed, it is difficult even to make any sense of what is happening unless we shift the lens and either dispense with notions such as “treatment” or, what seems more apt, seriously downplay them. The point is, despite the medical arena in which it is played out, what we appear to be seeing is battery, not legitimate treatment. And although battery is horrific regardless of who is being battered and so we must also be concerned for male victims, we are particularly seeing women targeted. Decades ago, Ollie May Bozarth, a psychiatric survivor, (1976) dubbed shock “a gentleman’s way to beat up a woman” (p. 27), and there appears to be merit to this description. Although the medicalization camouflages the assault, overwhelmingly electroshock constitutes an assault on women’s memory, brains, integral being. And this being the case, electroshock may be meaningfully theorized as a form of violence against women.

Something of the purpose of this violence is hinted at in Breggin’s (1991) reference to a colleague who urged a husband to agree to the shocking of his wife because it would help, functioning as a “mental spanking” (p. 212). As feminists, it is critical that we understand this violence better, however. And it is critical to approach the issue from the standpoint of those most effected and to make their testimony and the everyday problematics of their lives central to our inquiry.

Taking Seriously What the Women Survivors Say

Damage, Impairment, and Their Impact

Damage to the brain, impairment of memory and other cognitive functions, and the dismal effects on the women’s lives are particularly common themes that appear again and again in women survivors’ testimony. Significantly, although shock had not been described to them as something that would create any significant cognitive impairment, when they began receiving ECT, all 10 women shock recipients discussed in the article on women electroshocked in the Bay Area (Warren, 1988) thought that the purpose of electroshock was to erase memory. Correspondingly, all women shock survivors interviewed for the video (Burstow, 1994), all women shock survivors who testified in front of the Toronto Board of Health (Phoenix Rising Collective, 1984), and all but one woman survivor who testified in the 3 days of hearings at Toronto City Hall (Ontario Coalition to Stop Electroshock, 1984b) spoke at length about their difficulty navigating the world because of electroshock-induced damage. Most women testified that the damage was extensive, that much of it was permanent, and that it had profoundly disrupted their lives. All but one woman who testified at the public hearings called for the total abolition of ECT on the grounds of the damage done and the problems caused. Examples of specific problems listed by women include not being able to remember events that happened or people they knew before shock, not being able to

remember conversations, not being able to perform the kind of jobs that they once did, loss of skills, the sense of being diminished, and profound alienation.

Telling, in this regard, is the following excerpt from Connie Neil's testimony to the Toronto Board of Health:

I was . . . studying playwriting. As anybody knows, the kind of creative writing that you do . . . depends very strongly on what you are made up of, what your past memories are, your past relationships, how you deal with other people, how others deal with other people—all these things. I can't write any more. . . . Since the shock treatment, I'm missing between eight and fifteen years of memory and skills; and this includes most of my education. I was a trained classical pianist. . . . Well, the piano's in my house, but . . . it just sits there. I don't have that kind of ability any longer. It's because when you learn a piece and you perform it, it's in your memory. But it doesn't stay in my memory. None of these things stay in my memory. People come up to me . . . and they tell me about things we've done. I don't know who they are. I don't know what they're talking about, although obviously I have been friendly with them. Mostly what I had was . . . modified shock, and it was seen as effective. By "effective" I know that it is meant that they diminish the person. They certainly diminished me. . . . I work as a payroll clerk for the Public Works Department. I write little figures, and that's about all. . . . And it's the direct result of the treatment. (Phoenix Rising Collective, 1984, pp. 20A-21A)

Connie's comment on effectiveness is apropos. Although she was told nothing about any damage ensuing, she identified the same *modus operandi* and goal as the early shock doctors. "By effective," she stated, "I know that it is meant that they diminish the person." In line with this generalization, the life details that she relays indicate extensive antegrade and retrograde amnesia. They indicate cognitive impairment, skills loss. The results for her, as she articulated them, are interference in social functioning and profound personal, creative, and spiritual diminishment.

Damage to memory and profound interference in family and other social life are similarly highlighted in Shirley Johnstone's testimony (Phoenix Rising Collective, 1984):

The damage done to my brain . . . is still evident. . . . The memory loss is especially painful, since I could not remember a lot of times while the children were growing up. . . . The two older children—I do not remember their graduation. Many times, my family and friends would bring up happenings that I had to question them about, to test whether my memory would return. Usually not. I feel so alien because of this damage. I used to cover up a lot of times, thinking that if I listened more and rested a lot before going out, it would be easier. . . . One of my children's school interviews was terrifying, because I didn't want to reveal . . . the gaps in my memory—I was still in the closet. Finally when the anxiety got so bad, I would completely avoid people. (pp. 21A-22A)

Like Connie's testimony, Shirley's testimony speaks to brain damage and extensive memory impairment. Her testimony is particularly instructive, however, in revealing the social and psychological cost of the impairment. Memory loss isolates her from

others, interferes with her as a mother, and brings with it shame, alienation, anxiety, and a profound sense of being diminished.

Connie and Wendy (Funk), I might add, as well as numerous other women testified that they were given shock not long after the birth of a child. What their testimony suggests is that women are being subjected to brain damage at least, in part, to deal with the effects of postpartum depression, a completely natural phenomenon that everyone knows is temporary. And significantly, no one informed them they could be damaged this way. Indeed, no one warned any of the women in any of these sources that any extensive or permanent damage could ensue. The disrespect for women and women's brains is evident.

Further insight into the kind of life this impairment can force on women is found in Sue's statements in the Burstow (1994) video. She spoke of continued inability to remember conversation. "I'll be talking to you today," she pointed out, "and tomorrow, it'll be hard for me to recall a lot of our conversation" (n.p.). She spoke of needing to take notes throughout the day just to get by. Wendy Funk (1998) and Linda Macdonald (1988) revealed just how intransigent and extensive the memory loss can be. Wendy found herself being cared for by a husband and children whom she never came to remember. Linda spoke of what it means to navigate life without any memory of her life prior to shock. Although Linda is an extreme example, the overwhelming majority of the women in all the sources drawn on felt as if their life and identity were stolen from them.

Although it figures in the discourse less frequently and less urgently, some women additionally refer to more extensive bodily injury. For example, Wendy (Funk, 1998) referred to permanent damage to her knee as a result of the seizure. And Shirley, who was given modified or unilateral shock, and so would expectably be affected more on one side than the other, refers to general bodily weakness but particular weakness on the right side, stating:

It became very difficult to lift my lower spine and middle back. . . . When I am tired, there are times my mouth will not form words. At times, I have lost the use of my right arm and right leg. (quoted in Phoenix Rising Collective, 1984, p. 22A)

High-Level Categories: Assault and Trauma

Repeatedly, women's testimonies connote a sense of the entire process as an ongoing assault: being strapped down, being herded into the room, one's head being encased in a band, being unable to breathe, being rendered unconscious, having one's body violated by shock, being brain damaged. In this regard, one woman in the L. Johnstone (2002-2003) study reported, "I feel like I've been gotten at, bashed, as if my brain has been abused"; and another reported, "it can feel like a brutal assault on you" (p. 46). Some women explicitly identified the process as torture. Sue, for example, stated:

All the therapy in the world is not going to erase the scars of being dragged into a room, having a band on your head, and having your brains fried. People say there's no torture in

Canada. That's pure bullshit. And excuse my language. There is torture being paid for by the Ministry of Health. (quoted in Burstow, 1994, n.p.)

Figuring in the sense of assault is the sense of being treated like an animal, a sense of being led to the slaughter. A case in point is a survivor who explicitly spoke of "the feeling of being led to the slaughter on treatment mornings and knowing when they put the needle in, it meant blackness and waking up with the splitting headache and not knowing where my room was even" (quoted in Ontario Coalition to Stop Electroshock, 1984b, p. 180).

Assault, significantly, is traumatizing to varying degrees. It is not surprising to find, therefore, that although women seldom use the word *trauma* when referring to the process, women's testimonies blatantly speak to trauma and, indeed, to trauma in the extreme. Researcher Lucy Johnstone (2002-2003) identified electroshock-induced trauma in survivors of childhood sexual abuse who are shocked as adults. She also identified traumatic elements in all the women shock survivors interviewed in her study. The trauma, however, is more complete than even this author suggested, and it is very extensive and very pronounced. Testimony in all sources used for this article typically highlighted extreme states of terror, the feeling of being powerless, the sense of being humiliated and degraded, the subjective sense of annihilation, of dying. These typifications are in line with standard definitions of *trauma*: Herman (1992), for example, who defined *trauma* in terms of traumatizing events and responses involving terror, loss of control, the threat of annihilation. Although degradation, I would add, is not standard in all trauma, it is standard in trauma involving assault. Accordingly, the narratives may be construed as showing that ECT blatantly traumatizes women subjected to it and that the trauma in question is essentially the same as trauma traditionally associated with assault.

To break this down, terror is expressed by woman after woman who has been electroshocked, with terror frequently uniting with death imagery. "I felt as if I was dying every time one of them was administered," testified a woman at the Public Hearings (Ontario Coalition to Stop Electroshock, 1984b, p. 184). "I was terrified," asserted Funk (1998, p. 55). "You dread it," stated one of the women in L. Johnstone's study (2002-2003), "your heart starts pumping and here we go again. It's like going to your death, your doom" (p. 49). Annihilation, correspondingly, is particularly evoked in Connie's description: "Your heart's a muscle, and your lung's a muscle, and all of your muscles stop, and each time, you feel like you are dying, and then they shoot electricity through your head, and then you don't know anything" (quoted in Burstow, 1994, n.p.).

The feelings of humiliation and degradation are equally evident in the testimony, and as with the sense of death and doom, they are tied to the assault, to the sense of being purposefully mistreated. Telling in this regard are these descriptors quoted by Baldwin and Froede (1999): "I felt like an animal" and "they strip you of your self-worth" (p. 185). By the same token, a woman in the L. Johnstone (2002-2003) study remarked, "I felt as if I was a non-person and it didn't matter what anybody did to me"

(p. 49). Statements like these, it should be noted, are hauntingly similar to the statements we find in standard literature on domestic abuse (see, e.g., Martin, 1981).

Similarly, the women typically expressed a sense of having no control, of being powerless. For example, a woman at the public hearings testified, "I never felt so helpless in all my life" (quoted in Baldwin & Froede, 1999, p. 185). And L. Johnstone (2002-2203) typified the women in her study as expressing feelings and thoughts that connote being "helpless, out of control" (p. 49). The sense of helplessness joins with the sense of diminishment in women's depiction of themselves as being infantilized (see, e.g., Baldwin & Froede, 1999, pp. 184-185).

Terror, humiliation, and a sense of helplessness, significantly, stem at once from the damaging and terrorizing treatment in itself and from the treatment in the context of an institution that routinely wrests control away, that routinely traumatizes. The context is such, correspondingly, that it mutually constitutes the woman shock recipient as a powerless child who knows that she will not be heard, and the presiding male as all-powerful parent who knows what is best for this child and will enforce it. Velma Orlikow's compelling description illustrates one of the ways these different elements can come together in the traumatizing present:

I never saw him once that I wasn't afraid. Every time I saw him coming down the hall, I'd shake with fear. . . . I'd say, "I can't, I can't take it any more. I don't think this is doing me any good. I feel worse." And he'd walk down the hall a little way and put his arm on my shoulder and say, "Come on now, lassie, you know you're going to do it." (quoted in Burstow & Weitz, 1988, pp. 202-204)

As with all or almost all trauma, the effects of the trauma remain. It is significant to note, women explicitly refer to the low self-esteem and the sense of powerlessness continuing (see, e.g., Burstow, 1994). As is common in trauma, however, it is the ongoing fear that is most emphasized. Typical in this regard is Connie Neil's statement: "But the biggest thing, I think, is the business about the terror and the violence. This just doesn't go away. All I did was have a baby. And look what they did to me" (quoted in Burstow, 1994, n.p.).

Witnessing Trauma or Vicarious Traumatization

Just as others who witness standard woman battery are commonly traumatized on a long-term basis just by witnessing the violence, the electroshock hearings demonstrated vicarious or indirect trauma to psychiatric survivors who have not themselves been electroshocked. As the women clarified, the source of the trauma is witnessing people lined up on stretchers on ECT mornings, then discovering in horror what these same people look like in the days, weeks, and months that follow. "It was terrifying," testified one woman at the hearings,

it was really a terrifying experience to watch these people go through the process and then be totally out to lunch, not able to carry on a conversation, not able to recognize the people

they had close relationships with for the past three or four weeks, watching them being turned into instant vegetables. (Ontario Coalition to Stop Electroshock, 1984b, p. 161)

Another woman, Neira Fleischmann, testified that she was terrorized as a result of witnessing fellow patients subjected to electroshock, that it resulted in personal harm, and that she continued to have “regular nightmares about it” (see Ontario Coalition to Stop Electroshock, 1984b, pp. 215-216). Her testimony about being traumatized, moreover, is supported by her poetry, as seen in these lines in her poem “ECT”:

Outside the air grows heavy.
 I image spectacles of smoke and fire;
 Flashing burns and slow asphyxiation.
 I think of torture for breakfast.
 Eyes like smoldering charcoal
 Peer at me and turn away.
 I force myself to look (it's not a matter of decision).
 Feet twitch through half-open curtains
 Drops of blood around a bed
 A few electrodes on the floor, hastily discarded the memories they've seared
 Into ashes and ambers. (Fleischmann, 1988, pp. 220-221)

Nira had witnessed violence and had become the traumatized person that such witnessing engenders.

The Social Control of Women

The suggestion that electroshock is punishment is likewise supported by the testimony of women ECT survivors. Although not all women who experience electroshock as assault see it as punishment, the two typifications frequently go together. In this respect, Connie Neil stated, “It was meant to be punishment” (quoted in Burstow, 1994, n.p.). Correspondingly, women report having wondered at the time what they did wrong to deserve such punishment (see L. Johnstone, 2002-2003, p. 49).

Accompanying the theme of electroshock as punishment, though more pervasive than this theme, is the theme of electroshock as a form of control. The process itself, as has already been shown, is experienced as inherently controlling, with people brought in bound, with people losing consciousness, with people unable to breathe, with the male as powerful helper taking control of woman as the helpless child. More significantly, woman after woman maintained that despite the rationales used, the real purpose of the electroshock was social control. Cognitive impairment or memory loss was frequently identified as the means. The implicit rationale is: What cannot be remembered, cannot be repeated or acted on. Correspondingly, if people are so impaired that they cannot function, behavior seen as undesirable may be curtailed. It is not only those few women who later discovered they were subjected to electroshock for the expressed purpose of “depatterning” that equated ECT, cognitive impairment,

and intentional control; so did many other women in the sources examined (see, in particular, Funk, 1998; Ontario Coalition to Stop Electroshock, 1984b; Warren, 1988).

More commonly, women testified to being controlled via their fear of ECT. What women were testifying to, in effect, is that they are being kept in line, kept within certain bounds via the fear of further electrical assault and its results. Connie Neil, once again, is instructive. At the public hearings, she stated, "there was always the fear . . . that you are going to appear a little outside the norm. You must not be anything that is outside the norm because . . . if you are, you will be taken to a hospital, you will be strapped down, and you will be given electroshock" (Ontario Coalition to Stop Electroshock, 1984b, p. 90). She made the point even more forcefully in the Burstow (1994) video:

but the biggest thing . . . is the business about the fear and the violence. This is something that doesn't go away. All I did was have a baby. And look at what they did to me. Now if I really did something, what would they do to me next? So you be very very careful. You be very very quiet. . . . You fit in. You play a role. (n.p.)

The "mental spanking" referred to by Breggin's colleagues is apropos, though it trivializes what is happening here. ECT appears to be effective in the way abuse is always effective: by inspiring fear of further violation. There is evidence, additionally, that a vicious cycle sets in, with ECT used to stop women from complaining about the effects of ECT. Many women testified that they were chastised when they spoke of the treatments making them worse, were ordered to stop "acting out," and were warned that continued complaints would be interpreted as illness and would result in further "treatment." In addition, women reported protecting themselves by obeying (see, e.g., Funk, 1998).

Some women psychiatric survivors who had not been shocked similarly testified that the fear of shock had kept them in line, with a number implying that this control over them was purposeful or quasi-purposeful. For instance, one of the psychiatric survivors who testified at the hearings in this regard said, "and it was a threat to those of us who were not to receive ECT . . . to get our act together really quickly or else this was going to happen to us. It was never stated but it was implicit" (quoted in Ontario Coalition to Stop Electroshock, 1984b, p. 161).

Add all this together and what emerges is a picture of ECT functioning to eradicate thoughts and skills (including those on which independence is based), to punish, to threaten those given it and those witnessing it, and to silence objection even to the assault itself. What emerges, in other words, is a formidable and comprehensive method of social control. The fact that such control is primarily exercised over women would raise the question of gender role enforcement, even if women's own testimony did not suggest it. Women's testimony, however, clearly suggests it.

To varying degrees and in varying ways all of the women's testimonies suggest patriarchal control, with many of the women experiencing themselves as being overtly kept in line as women. One of the themes that recurs in the sources is ECT used to

enforce heterosexuality. An example is Sheila Gilhooly, who reported being electroshocked explicitly for her sexual preference:

I told my shrink I didn't want to be cured of being a lesbian. He said that just proved how sick I was. He said I needed shock treatment. . . . Nineteen shock treatments, and I still didn't want to be cured of being a lesbian. (quoted in Blackbridge & Gilhooly, 1988, p. 45)

Electroshock to keep women sexually unavailable to other women is evident.

Control over wives figures particularly centrally, generally with the psychiatrist seeking this control, sometimes with the husband tricked into cooperating, sometimes with the husband actively instigating, frequently with the husband colluding with the medical profession so that women end up caught in a comprehensive medical-marital web of control.

Wendy Funk's (1998) story explicitly focuses on electroshock as wife control. In 1989, Wendy was subjected to electroshock largely at the instigation of a doctor. Commenting on the sexism, Wendy reported the following conversation between her husband and the doctor:

"Can't you tell her to . . . spend more time at home?" Dr. King asked.
 "I try but she doesn't listen to me," Dan joked.
 "So you can't control your wife's behavior?" Dr. King asked. (p. 15)

Dr. King "explained" to Wendy that her "problem" arose from neglecting her house and being consumed by "feminist-type thinking" (p. 48). Locked in a psychiatric institution, with her husband urging cooperation and her doctor threatening to ship her far from her family if she did not agree to shock, Wendy signed for and was subjected to a series of ECT. Despite the extensive amnesia that resulted, Wendy wrote that the psychiatrist later pressured for further shock, telling her, "You really should have ECT for the sake of your family if nothing else. Making Dan worry about you so much is not a good thing for a wife to do" (p. 91). Patriarchal enforcement of stereotypical wife and mother behavior is evident, in this case with doctor as instigator and husband as reluctant participant.

The stories of the women who testified at the public hearings, the stories in the videos, and the stories in the feminist research suggest that patriarchal conceptualizations of wives and mothers permeate the use of electroshock. Although the influence of such conceptualizations was sometimes subtle, in many instances it was very blatant indeed. "Why don't you care for your baby? Why don't you care for your husband? Why don't you smarten up?" Connie Neil reported being asked before the electrical assaults began (quoted in Ontario Coalition to Stop Electroshock, 1984b, p. 87). A number of women explicitly saw shock's purpose as "fixing" the problems in the marriage with "fixing" them as the route, and they were duly angry. "Shock treatment is a helluva of a way to treat marital problems," objected one woman in the Warren study (1988, p. 296).

Most of the women survivors at the hearings and most of the women in the research received ECT as a result of their husband signing the consent form. In some cases, husbands appeared to have signed without any clear idea what ECT would do to their wives. In others, there is reason to believe that they were aware that the wives would be harmed in some way and were counting on it (see Warren, 1988).

In a number of cases, the husbands even openly lauded the memory loss. In the Warren study (1988), not only the women who were electroshocked but also their families were interviewed, and many husbands expressed satisfaction with the memory loss. For example, according to Warren (1988),

Mr. Karr commented on his wife's long-term memory loss as proof of her successful cure by ECT, saying that her memory was still gone, especially for the period when she felt ill, and that "they had done a good job there." These husbands used their wives' memory loss to establish their own definitions of past situations in the marital relationship. (p. 294)

As a number of these sources show, the combination of husband plus medical establishment plus threat of further ECT functions to inspire fear and thereby control women. Once again, women in Warren's (1988) study are instructive. A number of the interviewees spoke of refraining from expressing problems to their husbands, "for fear of a resumption of medical-marital control of their lives . . . for fear of reprisal in the form of ECT" (p. 296). Broader ways in which husbands are implicated in the medical-marital web of control include signing for consent, pressuring wives to sign for consent, suggesting shock, acting as a spy for the shock doctor, advising the doctor of "bad behavior," and threatening to report noncompliance (see Burstow, 1994; Funk, 1998; Ontario Coalition to Stop Electroshock, 1984b; Warren, 1988).

Control stories such as Wendy's and Connie's are commonplace. Indeed, at the hearings, as women survivors spoke of the social control exercised over them, I saw women throughout the room nodding their heads in recognition. Correspondingly, there is objective proof of far more extreme uses of electroshock to control women. In this regard, in the Allen Memorial, wiping the mind clean via electroshock was combined with implanting messages via a tape recorder that played the exact same message thousands and thousands of times as the patients slept. An example of the message given one woman who was anything but at ease with her husband was "you are at ease with your husband" (quoted in Gillmor, 1987, p. 58). Correspondingly, family psychiatrist H. C. Tien openly used electroshock to effect what he called "memory loosening" with women in "marital difficulty." Transcripts of dialogues between Tien and one married couple show the woman prior to shock complaining that her husband beat her in front of the children and stating her wish to leave him. After each ECT, at Tien's instigation, the woman was reprogrammed by her husband, who bottle fed her. In the end, the woman expressed satisfaction with her husband, was pronounced cured, and was given a new name to symbolize her rebirth; and she no longer expressed any wish to separate (for documentation, see Breggin, 1991).

Electroshock Following Other Violence Against Women

Adding to the complexity of understanding ECT as violence against women, as the example above suggests, are complex relationships between having already been subjected to another form of violence against women and being subjected to ECT. Approximately one half of the shock survivors interviewed in the video (Burstow, 1994) reported having told their psychiatrists that their current emotional distress was a direct response to being sexually abused by a male relative or being battered by a male partner. In some cases—Usha, for example—they were currently being abused. In all instances, according to the women, nothing happened to the abusive relatives or partners; however, the women were electroshocked. Commonly, the women were accused of making up the abuse. Even when psychiatric staff did not deny the abuse, they nevertheless largely ignored it. Usha's situation is instructive:

Bonnie: Let me ask you something I don't understand. And maybe you could explain this to me. Nowhere did they say that your husband should stop beating you and abusing you and that [the abuse] may have something to do with what's happening to you?

Usha: No. They didn't even want to listen to me that my husband was doing something to me and that it's because of that I'm so much stressed out and so sad.

Bonnie: So you told them about it and what did they say?

Usha: They just ignored it, no? (quoted in Burstow, 1994, n.p.)

At best, electroshock appears to be used to control rather than help women here. At worse, electrical assault is also being used to silence women about their abuse.

In addition, although I am not suggesting that this is standard, as the women in a number of these sources revealed, sometimes more blatant types of silencing figure in the use of electroshock. Significantly, a woman in the video who had been sexually abused by her psychiatrist reported him threatening not only to deny the abuse but also to electroshock her if she ever divulged it. Other women reported comparable threats by abusive male relatives. Violence, punishment, silencing through intimidation, and silencing through the eradication of memory come together in such threats.

By the same token, sometimes women are electroshocked because relatives are jointly using ECT's capacity to eradicate memory to deal with accusations within the family. A woman in the Warren study (1988) appears to be a case in point. According to her, she was sexually abused by her maternal uncle. The relatives denied the abuse, and her mother pushed to have her institutionalized and electroshocked. The woman stated:

Before we left the house . . . she [mother] was explaining [to other relatives] why she wanted me up here, you know, she wants me to have the full treatment, she says. . . . She said that she thought it would make me forget all those things. . . . My mother wants me to have shock so that I'll forget all those things that happened. (p. 294)

Although the mother may well have convinced herself that she was simply sparing her deluded daughter further torment, the woman was effectively silenced regardless (for

other examples of family members using shock this way, see Burstow, 1994; Ontario Coalition to Stop Electroshock, 1984b).

Some of the types of silencing suggested here, I would add, are confirmed in my own psychotherapy practice. I have had one client who spoke of a psychiatrist threatening her with shock if she ever divulged that he had abused her, and let me be clear, this client was highly credible. In addition, throughout the years, I have had a number of clients who have spoken of their fathers' signing for ECT after they themselves began divulging father-daughter sexual abuse. And I have had still other clients who have spoken of their sisters being institutionalized and electroshocked after confronting the family about abuse.

Messages that women predictably get from such invalidation, violation, and threat of violation are: Complaints are counterproductive. The world really is fundamentally unsafe for women, especially women pronounced mad. And so, as Connie put it, it is best to "fit in," to "play a role" (quoted in Burstow, 1994, n.p.).

What is more fundamental, and what makes the issue of prior violence still more complex, is the fact that women who are severely violated are in special jeopardy of ECT, whether or not ECT is being used in the service of silencing. Correspondingly, they are likely to be more affected by it regardless of intention, interpretation, or situation. In this regard, as multiple sources demonstrate (e.g., Burstow, 1992, 1994; Burstow & Weitz, 1988), women routinely end up in psychiatric institutions precisely because of violence against them. Indeed, the majority of the 19 women who were psychiatrized and interviewed for the Burstow (1994) video indicated that they had an extensive background of violation, childhood sexual abuse in particular. When incarcerated, women with such a history are at risk of ECT not only because they are frequently depressed but also, as demonstrated in Burstow (1992), they commonly cope in the traumatized ways that psychiatry theorizes as dangerous, such as cutting themselves or starving themselves. Correspondingly, if they are electroshocked, as L. Johnstone (2002-2003) demonstrated, retraumatization occurs. As such, ECT constitutes a threat to the well-being of women who are violated and one of the ways in which the violence against women is compounded.

Concluding Remarks / A Vital Additional Consideration

There is no question that women can find themselves in severe emotional distress and in need of help. And there is no question that most practitioners who administer ECT are more or less convinced that they are helping, for they are fashioned by the psychiatric profession and its norms. Nonetheless, as this article demonstrated, electroshock is a part of the repertoire of the patriarchy; and it functions as a fundamental patriarchal assault on women's brains, bodies, and spirits. It is an assault that has much in common with traditional battery. It is traumatizing, even traumatizing "patients" who only witness it. It controls women and, indeed, is used to control women. It combines with other forms of violence against women. It is a special threat to women who

are severely violated. And is used to silence women. As such, its very use is a feminist issue.

I am aware that some women would be worried about throwing out the proverbial baby with the bath water and would suggest simply mobilizing against the sexism inherent in ECT use. As this article demonstrated, however, although highlighting the sexism is important, trying to make the electroshock industry less sexist is hardly sufficient. Although it may or may not be possible to tone down the sexism that has been endemic in the use of electroshock, the statistic of 2 to 3 times as many women as men who were electroshocked is not promising. Moreover, social control over women and violence against women are hardly disappearing. What is even more fundamental, it is not possible to make the procedure itself something other than what it is: electrically induced brain damage that severely and routinely diminishes people subjected to it and that has no medical efficacy. Given its nature, it is unacceptable to subject anyone to it regardless of the intention or sensitivity of the people administering it. And given its nature, it will inevitably be used on those whose brains are valued less.

In ending, I would like to introduce a new development in the ECT saga that needs to be considered. Throughout most of its history, electroshock has been aimed primarily at young and middle-aged women—hence, the profile of women in these sources and, indeed, in all relevant sources. Times, however, have changed. For the year 1999 to 2000, as shown in Weitz (2001), 40% of the number of people shocked in provincial psychiatric institutions in Ontario were women older than age 60 years, and 52% of the total electroshock administered was administered to women older than age 60 years. Similar statistics may be found for other jurisdictions. In other words, at this juncture at least, though young and middle-aged women remain in jeopardy, disproportionately we are looking at elder abuse, the abuse of older women in particular. Although this is a horrific development, it is not surprising, for older women are not valued by dominant cultures.

Given that the elderly are already struggling with memory problems, given the general vulnerability of this population, and given the resurgence in electroshock, there is an urgency to the situation at hand. This is a development that calls for new types of feminist activism. Correspondingly, it calls for new research into electroshock, including feminist interviews with a population that has not been interviewed on this issue to date and is likely to prove enormously difficult to access.

References

- Avery, D., & Winokur, G. (1977). The efficacy of electroconvulsive therapy and antidepressants in depression. *Biological Psychiatry*, 33, 1029-1037.
- Baldwin, S., & Froede, E. (1999). Toronto public hearings on electroshock. *International Journal of Risk and Safety in Medicine*, 12, 181-192.
- Black, D., & Winokur, G. (1989). Does treatment influence mortality in depressives? *Annals of Clinical Psychiatry*, 1, 165-173.
- Blackbridge, P., & Gilhooly, S. (1988). Still sane. In B. Burstow & D. Weitz (Eds.), *Shrink-resistant: The struggle against psychiatry in Canada* (pp. 44-54). Vancouver, Canada: New Star.

- Bozarth, O. (1976, June). Shock. *Madness Network News*, 26, 6.
- Breggin, P. (1979). *Electroshock: Its brain-disabling effects*. New York: Springer.
- Breggin, P. (1991). *Toxic psychiatry*. New York: St. Martin's.
- Breggin, P. (1997). *Brain-disabling treatment in psychiatry*. New York: Springer.
- Breggin, P. (1998). Electroshock: Scientific, ethical, and political issues. *International Journal of Risk and Safety in Medicine*, 11, 5-40.
- Burstow, B. (1992). *Radical feminist therapy: Working in the context of violence*. Newbury Park, CA: Sage.
- Burstow, B. (1994). *When women end up in those horrible places* [Video]. Toronto, Canada: Author.
- Burstow, B., & Weitz, D. (1984). Electroshock. *Phoenix Rising*, 4(3 & 4), 10A-12A.
- Burstow, B., & Weitz, D. (Eds.). (1988). *Shrink-resistant: The struggle against psychiatry in Canada*. Vancouver, Canada: New Star.
- Calloway, S. (1981). ECT and cerebral atrophy. *Acta Psychiatrica Scandinavica*, 64, 441-445.
- Cameron, E., Lohrens, J., & Handcock, K. (1962). The depatterning treatment of schizophrenia. *Comprehensive Psychiatry*, 3, 65-76.
- Crowe, T., & Johnstone, E. (1986). Controlled trials of electroconvulsive therapy. *Annals of the New York Academy of Science*, 462, 12-29.
- Electro-Convulsive Therapy Review Committee. (1985). *Report of the Electro-Convulsive Therapy Review Committee*. Toronto, Canada: Author.
- Fink, M. (1973). *Convulsive therapy*. New York: Raven.
- Fleischmann, N. (1988). ECT. In B. Burstow & D. Weitz (Eds.), *Shrink-resistant: The struggle against psychiatry in Canada* (pp. 220-222). Vancouver, Canada: New Star.
- Frank, L. (1978). *The history of shock treatment*. San Francisco: NAPA.
- Funk, W. (1998). *What difference does it make?* Cranbrook, Canada: Wild Flower Publishing.
- Gilmore, D. (1987). *I swear by Apollo*. Montreal, Canada: Eden.
- Grobe, J. (1995). *Beyond bedlam*. Chicago: Third Side Press.
- Grosser, G. (1975). The regulation of electroshock treatment in Massachusetts. *Massachusetts Journal of Mental Health*, 5, 12-25.
- Hartelius, H. (1952). Cerebral changes following electrically induced convulsions. *Acta Psychiatrica Neurologica Scandinavica*, 77(Suppl), 1-128.
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- Johnstone, E. (1980). The Northwick Park ECT trial. *Lancet*, 100, 1317-1320.
- Johnstone, L. (2002-2003). Electroshock in UK linked to psychological trauma. *MindFreedom Journal*, 45, 48-50.
- Lambourne, J., & Gill, D. (1978). A controlled comparison of simulated and real ECT. *British Journal of Psychiatry*, 113, 514-519.
- Macdonald, L. (1988). Breakthrough. In B. Burstow & D. Weitz (Eds.), *Shrink-resistant: The struggle against psychiatry in Canada* (pp. 206-210). Vancouver, Canada: New Star.
- Martin, D. (1981). *Battered wives*. San Francisco: Volcano Press.
- MindFreedom. (2002-2003). Electroshock's secret comeback. *MindFreedom Journal*, 45, 1-5.
- Ontario Coalition to Stop Electroshock. (1984a). *The case against electroshock*. Toronto, Canada: Author.
- Ontario Coalition to Stop Electroshock. (1984b). *Public hearings on electroshock* [Transcripts of testimony presented at city hall on October 13, October 20, and October 27, 1984]. Toronto, Canada: Author.
- Phoenix Rising Collective. (Ed.). (1984). Testimony on electroshock. *Phoenix Rising*, 4(3 & 4), 16A-22A.
- Smith, D. (1987). *The everyday world as problematic*. Toronto, Canada: University of Toronto Press.
- Szasz, T. (1977). *The manufacture of madness*. New York: Harper Colophon.
- Templer, D., & Veleber, D. (1982). Can ECT permanently harm the brain? *Clinical Neuropsychology*, 4(2), 62-66.
- Templer, D., Ruff, C., & Armstrong, G. (1973). Cognitive impairment and degree of psychosis in schizophrenics given many electroconvulsive treatments. *British Journal of Psychiatry*, 123, 441-443.
- Warren, C. (1988). Electroconvulsive therapy, the self, and family relations. *Research in the Sociology of Health Care*, 7, 283-300.

Weinberger, D. (1979). Lateral ventricular enlargement in chronic schizophrenia. *Archives of General Psychiatry*, 36, 735-739.

Weitz, D. (2001). *Ontario electroshock statistics* [Unpublished figures released under the Freedom of Information Act]. Toronto, Canada: Province of Ontario, Ministry of Health.

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